# GEORGIA MEDICAID FEE-FOR-SERVICE
## ANTIDIABETIC AGENTS PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
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<tbody>
<tr>
<td><strong>Preferred Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</strong></td>
<td><strong>Non-Preferred DPP-4 Inhibitors</strong></td>
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<tr>
<td>Januvia (sitagliptin)</td>
<td>Alogliptin 6.25mg, 12.5mg generic</td>
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<tr>
<td>Janumet (sitagliptin/metformin)</td>
<td>Alogliptin/metformin generic</td>
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<tr>
<td>Jentadueto (linagliptin/metformin)</td>
<td>Alogliptin/pioglitazone</td>
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<tr>
<td>Kombiglyze (saxagliptin/metformin)</td>
<td>Janumet XR (sitagliptin/metformin ER)</td>
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<tr>
<td>Onglyza (saxagliptin)</td>
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<tr>
<td>Tradjenta (linagliptin)</td>
<td>Nesina 25mg (alogliptin)</td>
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<tr>
<td><strong>Preferred Meglitinides</strong></td>
<td><strong>Non-Preferred Meglitinides</strong></td>
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<tr>
<td>Repaglinide generic</td>
<td>Nateglinide generic</td>
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<tr>
<td>Starlix (nateglinide)</td>
<td>Prandimet (repaglinide/metformin)</td>
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<td><strong>Preferred Metformin Products</strong></td>
<td><strong>Non-Preferred Metformin Products</strong></td>
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<tr>
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<td>Metformin ER generic</td>
<td>Glumetza ER (metformin SR 24hr)</td>
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<td>Riomet (metformin)</td>
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<tr>
<td><strong>Preferred Sulfonylureas</strong></td>
<td><strong>Non-Preferred Sodium-Glucose Co-Transporter 2 (SGT2) Inhibitors</strong></td>
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<tr>
<td>Glimepiride generic</td>
<td>Farxiga (dapagliflozin)</td>
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<tr>
<td>Glipizide generic</td>
<td>Glyxambi (empagliflozin/linagliptin)</td>
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<tr>
<td>Glyburide generic</td>
<td>Invokamet (canagliflozin/metformin)</td>
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<tr>
<td><strong>Preferred Thiazolidinediones (TZD)</strong></td>
<td><strong>Invokamet XR (canagliflozin/metformin ER)</strong></td>
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<tr>
<td>Pioglitazone generic</td>
<td>Invokana (canagliflozin)</td>
</tr>
<tr>
<td><strong>Preferred Miscellaneous Antidiabetic Agents</strong></td>
<td><strong>Jardiance (empagliflozin)</strong></td>
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<tr>
<td>Bydureon (exenatide ER)*</td>
<td>Synjardy (empagliflozin/metformin)</td>
</tr>
<tr>
<td>Byetta (exenatide)*</td>
<td>Synjardy XR (empagliflozin/metformin ER)</td>
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<td>SymmlinPen (pramlintide)*</td>
<td>Xigduo XR (dapagliflozin/metformin ER)</td>
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<td>Victoza (liraglutide)*</td>
<td><strong>Non-Preferred Sulfonylureas</strong></td>
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<td>Acarbose generic</td>
<td>Tolazamide generic</td>
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<td>Miglintol generic</td>
<td>Tolbutamide generic</td>
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<tr>
<td><strong>Non-Preferred Thiazolidinediones (TZD)</strong></td>
<td>Actoplus Met XR (pioglitazone/metformin ER)</td>
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<tr>
<td></td>
<td>Avandia (rosiglitazone)</td>
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<tr>
<td></td>
<td>Avandamet (rosiglitazone/metformin)</td>
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<tr>
<td></td>
<td>Pioglitazone/glimepiride generic</td>
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</tbody>
</table>

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**Non-Preferred Miscellaneous Antidiabetic Agents**

- Adlyxin (lixisenatide)
- Cycloset (bromocriptine)
- Soliqua (insulin glargine/lixisenatide)
- Tanzeum (albiglutide)
- Trulicity (dulaglutide)
- Xultophy (insulin degludec/liraglutide)

*Preferred agents that require prior authorization (PA); ER/SR/XR=extended-release

**LENGTH OF AUTHORIZATION:** Varies

**NOTES:**

- Criteria for insulins is located in the Insulins PA Summary and for diabetic supplies insulin pens is located in the Diabetic Supplies Insulin Pens PA Summary.
- If generic repaglinide/metformin is approved, the PA will be issued for brand Prandimet.

**PA CRITERIA:**

**Alogliptin 6.25mg, 12.5mg Generic and Nesina 25mg**

- Approvable for members with type 2 diabetes mellitus who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to Januvia, Onglyza and Tradjenta

**Alogliptin/Metformin Generic and Janumet XR**

- Approvable for members with type 2 diabetes mellitus who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to Janumet, Jentadueto and Kombiglyze

**Alogliptin/Pioglitazone Generic**

- Prescriber must submit a written letter of medical necessity stating the reasons the separate products, generic pioglitazone and brand Nesina 25mg or generic alogliptin 6.25mg or 12.5mg as well as Januvia, Onglyza and Tradjenta, are not appropriate for the member.

**Jentadueto XR**

- Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Tradjenta and generic metformin ER, are not appropriate for the member.

**Nateglinide Generic**

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Starlix, is not appropriate for the member.

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Prandimet and Repaglinide/Metformin Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, generic repaglinide and generic metformin, are not appropriate for the member.

Fortamet ER, Glumetza ER and Metformin SR 24hr Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic metformin ER, is not appropriate for the member.

Farxiga, Invokame, Invokame XR, Invokana and Jardiance

- Approvable for members 18 years of age or older with type 2 diabetes mellitus who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to metformin and either a thiazolidinedione or sulfonylurea AND
  - Submit documentation of hemoglobin A1c results within the past 6 months.
  - In addition for Jardiance, approvable for members 18 years of age or older with type 2 diagnosis who also have established cardiovascular disease (history of coronary artery disease, stroke or peripheral artery disease).

Glyxambi

- Approvable for members 18 years of age or older with type 2 diabetes mellitus who have experienced an inadequate response to Janumet, Jentadueto or Kombiglyze after 3 months AND
  - Submit documentation of hemoglobin A1c results within the past 6 months.

Synjardy

- Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jardiance and generic metformin, are not appropriate for the member.

Synjardy XR

- Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jardiance and generic metformin ER, are not appropriate for the member.

Xigduo XR

- Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Farxiga and generic metformin ER, are not appropriate for the member.

Chlorpropamide Generic, Tolazamide Generic and Tolbutamide Generic

- Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to at least 2 preferred sulfonylurea products.

Actoplus Met XR

- Physician must submit a written letter of medical necessity stating the reasons the preferred separate products, generic pioglitazone and generic metformin ER, are not appropriate for the member.

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Avandia and Avandamet
- Approvable for members with type 2 diabetes mellitus who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to pioglitazone.

Pioglitazone/Glimepiride Generic
- Physician must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone and generic glimepiride, are not appropriate for the member.

Pioglitazone/Metformin Generic
- Physician must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone and generic metformin, are not appropriate for the member.

Byetta, Bydureon and Victoza
- Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin, sulfonylurea and/or thiazolidinedione therapy
  
  **AND**
  - Submit documentation of hemoglobin A1c results within the past 6 months.
  - In addition for Victoza, approvable for members 18 years of age or older with type 2 diagnosis who also have established cardiovascular disease (history of coronary artery disease, stroke or peripheral artery disease).

SymlinPen
- Approvable for members 18 years of age or older with type 1 or type 2 diabetes mellitus currently on insulin therapy
  
  **AND**
  - Submit documentation of hemoglobin A1c results within the past 6 months.

Adlyxin, Tanzeum and Trulicity
- Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin, sulfonylurea and/or thiazolidinedione therapy who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or intolerable side effects to Byetta or Bydureon and Victoza
  
  **AND**
  - Submit documentation of hemoglobin A1c results within the past 6 months.

Soliqua
- Approvable for members who have been stabilized on combination therapy with the individual agents, Lantus and Adlyxin.
- Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin who have experienced inadequate response to combination therapy with Lantus and Victoza as well as combination therapy with Lantus and Byetta or Bydureon, or have experienced allergies, contraindications, drug-drug interactions, or intolerable side effects to metformin, Byetta or Bydureon and Victoza.
  
  **AND**
  - Submit documentation of hemoglobin A1c results within the past 6 months.
Xultophy

- Approvable for members who have been stabilized on combination therapy with the individual agents, Tresiba and Victoza.
- Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin who have experienced inadequate response to combination therapy with Lantus and Victoza as well as combination therapy with Levemir and Victoza, or have experienced allergies, contraindications, drug-drug interactions, or intolerable side effects to metformin, Lantus and Levemir.

**AND**

- Submit documentation of hemoglobin A1c results within the past 6 months.

Cycloset

- Approvable for members with type 2 diabetes mellitus who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to metformin, sulfonylurea, thiazolidinedione and dipeptidyl-peptidase-4 inhibitor.

**AND**

- Submit documentation of hemoglobin A1c results within the past 6 months.

**EXCEPTIONS:**

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

**PREFERRED DRUG LIST:**

- For online access to the Preferred Drug List (PDL), please go to [http://dch.georgia.gov/preferred-drug-lists](http://dch.georgia.gov/preferred-drug-lists).

**PA and APPEAL PROCESS:**

- For online access to the PA process, please go to [http://dch.georgia.gov/prior-authorization-process-and-criteria](http://dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- For online access to the Quantity Level Limits (QLL), please go to [https://www.mmis.georgia.gov/portal](https://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.

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